Adam Bruggeman, MD

Advocacy, Practice Efficiency & the Future of Orthopedics

Adam Bruggeman, MD, MHA, FAAOS, FAOA, FABPM, FASAM Orthopedic Spine Surgeon Dr. Bruggeman is a nationally recognized Orthopedic spine surgeon and healthcare executive. From the beginning of his career, he has balanced the various aspects of healthcare including policy, business, and clinical care. After completing his degree in Health Administration and Policy at Creighton University, he turned down medical school to pursue a masters in healthcare administration at Trinity University in San Antonio.

While working at HCA's Methodist Healthcare System in San Antonio, he reapplied to medical school, ultimately attending the University of Texas Health Science Center San Antonio. This unique background has guided his career and made him a highly sought after voice in healthcare. While building his practice in spine surgery, Dr. Bruggeman became very interested in the intersection of mental health, prescription opioids, and musculoskeletal care. Through his experience with patients struggling to navigate surgical care while dealing with chronic opioid usage, depression, anxiety, social issues, and other determinants of outcomes, he pursued a second board certification in addiction medicine. Dr. Bruggeman ultimately achieved the certification (believed to be the first dual boarded orthopedic surgeon and addiction medicine physician) and started an opioid treatment facility to help patients safely reduce their dependence on opioid medications as well as helping those in the community who were utilizing illegal or inappropriately acquired substances. Through the successes they had with weaning patients off opioids, Dr. Bruggeman believed that he could be even more instrumental in reducing the opioid epidemic by creating a preoperative clearance program that identified and treated opioid dependence, mental health factors, and social determinants that inhibit optimal outcomes. The PREOP Center continues to lead in cost effectiveness, patient satisfaction, and data-driven decisions on perioperative care.

Outside of clinical care, Dr. Bruggeman is a physician leader for multiple organizations, including those in artificial intelligence, prior authorization, value-based care, and a growing healthcare system in Texas. He also volunteers his time on the Board of Directors of the American Academy of Orthopaedic Surgeons (AAOS) as the chair on the council on advocacy. Through this position, he provides guidance and oversight of the AAOS political action committee, legislative initiatives, and all regulatory efforts (including CMS, HHS, FDA, and other federal organizations). Dr. Bruggeman is a key thought leader on health policy and advises multiple members of congress on issues revolving around healthcare in Washington DC. In addition, he has been named as a member of the prestigious American Orthopaedic Association and recognized by his peers as a Texas Super Doctor every year since 2015.

Hot Topics:

Physician Efficiency, Physician Influence in Advocacy, Future of Orthopedics

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Physician Efficiency

General Concepts

- Working at the “top of their license”
  - Limit non clinical tasks
  - Increase utilization of midlevels for postop, injections; focus surgeon on decision making, surgery, and difficult patients
- Embracing technology to assist for those that are technologically savvy
  - Generative/Ambient AI
  - Optimized EHR

Pre-Visit

- Ensure an appropriately set up EHR
  - How can we reduce clicks? Reduce information that needs to be entered?
  - Getting patients to fill out information in advance of your visit so the clinic can be reviewed
- Utilizing midlevels to “prep” clinic
- Pre-order imaging if/as appropriate
- Pre-drawn meds for injections? Peel packed or pre-prepped trays for procedures?

Clinic Day/Visit

- Room the patients at or before the time of the office visit - keep patients moving for both patient and physician satisfaction
- Depending on the physician, it may be appropriate to bring in a scribe or utilize ambient scribes (Watch for AI options over the next 12 months)
- Clear understanding of roles and responsibilities as well as urgency of tasks
  - What needs to be done now? After clinic? Who does it? How do we stay efficient in “crunch time” (during clinic)

Operative Days

- Updated H&P on the chart
- Medications addressed (preferably in advance)
- Clear and frequent communication with patient on time to arrive. Let the patient know your office may be calling if we are ahead of schedule or there is a cancellation day of
- Two rooms with one anesthesia? Two rooms and two teams?
- Communication with hospital, anesthesia, implant companies, etc… Discuss and confirm receipt

Physician Influence in Advocacy

Why?

- You are either at the table or you are on the table
- Physicians still hold importance in Austin and DC
- It impacts how we practice, where we practice, and ultimately patient outcomes

How?

- Be Present
- Team up with state (TOA) and national (AAOS, AAHKS, OrthoForum) organizations to take time to meet with members of legislature
- Be knowledgeable
- Be specific

What?

- Physician Owned Hospitals
- Prior Authorization Reform
- Medicare Payment Reform
- Physician Led Bundles
- Medical Liability Reform
- Equality with Telehealth
- Physician and Staff Safety
- Reducing Physician Burden

Does It Work?

- Reduced Medicare Cuts Annually
- Prior Authorization Reform in Texas (DC soon to follow?)
- Scope Creep Limited
- Liability Reform

118th AAOS Agenda

- Reform prior authorization and coverage reviews
- Encourage physician burden relief
- Telemedicine policies that promote equal reimbursement with in-person visits
- Encourage surgeon led value-based programs and surgeon led care teams
- Support medical liability reform at the state and local level
- Support repealing the ban on physician owned hospitals

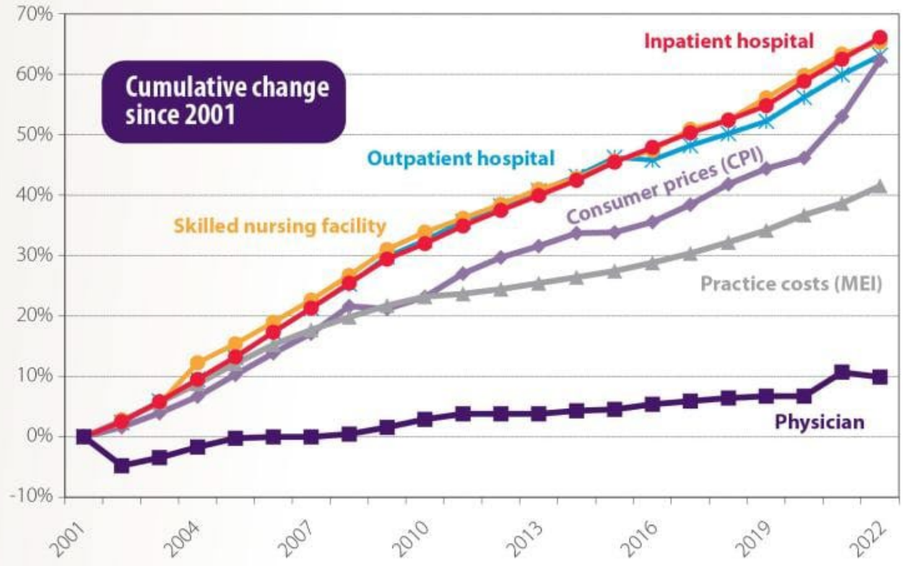
Future of Orthopedics

Medicare physician payment is not keeping up with inflation. Why are physician services taking a backseat?

Medicare updates compared to inflation (2001–2022)

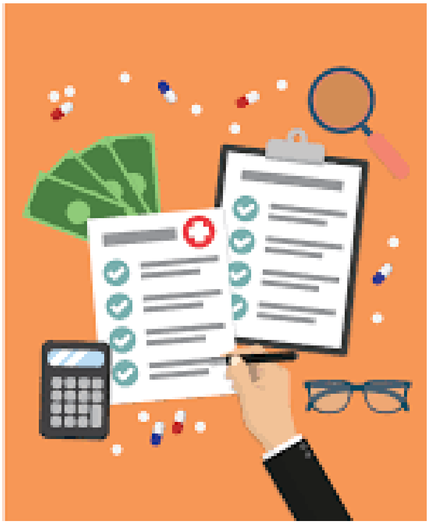
Adjusted for inflation in practice costs, Medicare physician payment declined 22% from 2001 to 2022.

AMA AMERICAN MEDICAL ASSOCIATION



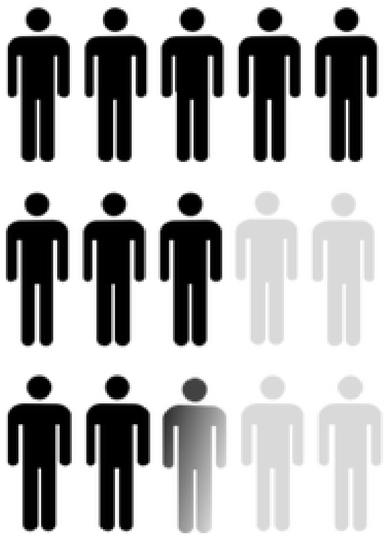
Sources: Federal Register, Medicare Trustees' Reports and U.S. Bureau of Labor Statistics, American Medical Association, Economic and Health Policy Research, September 2022.

Value-Based Care vs. Fee for Service: Are We There Yet?



Consolidation in Healthcare

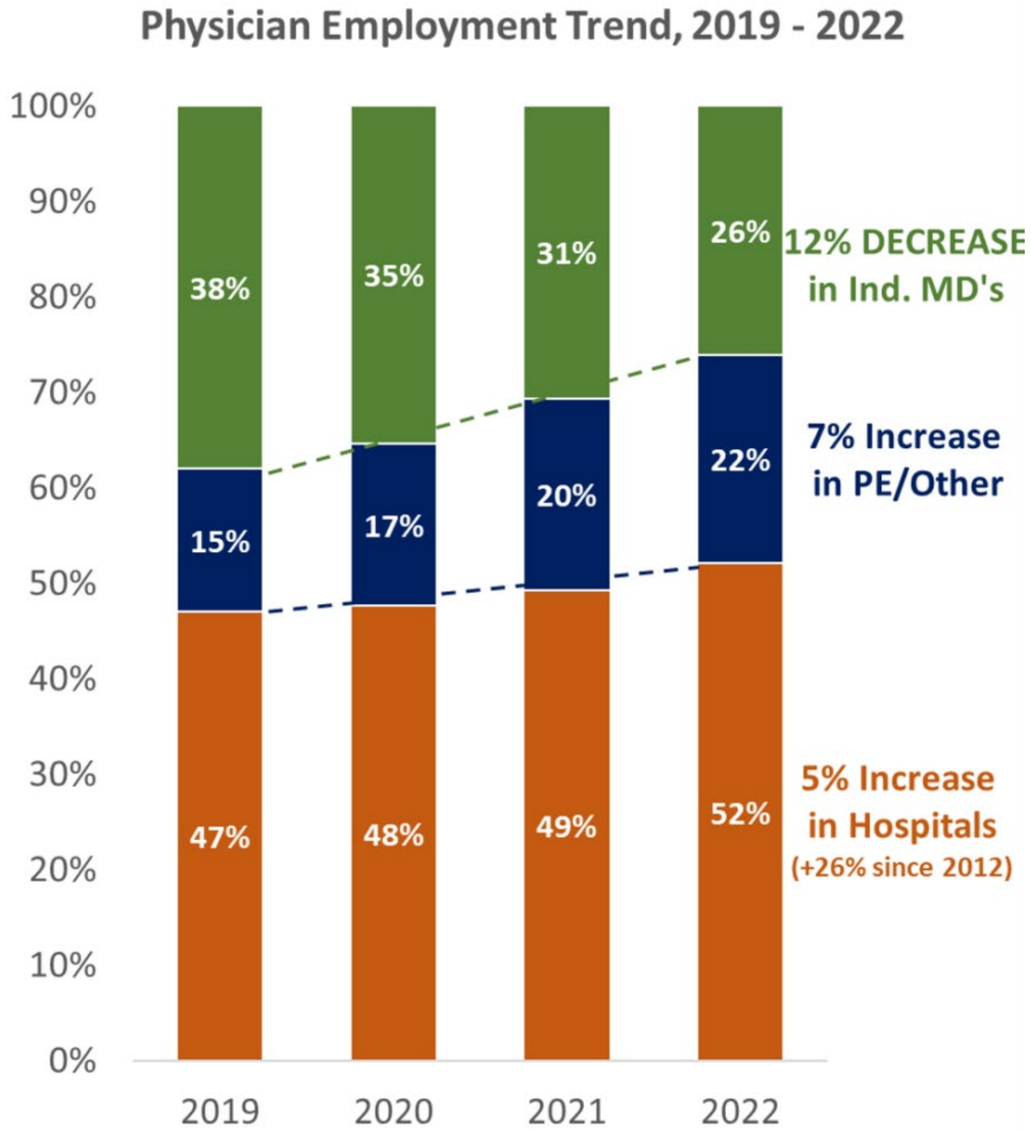
CONSOLIDATION AMONG HOSPITALS AND PHYSICIANS



95% % of physicians who were independent in **2000**

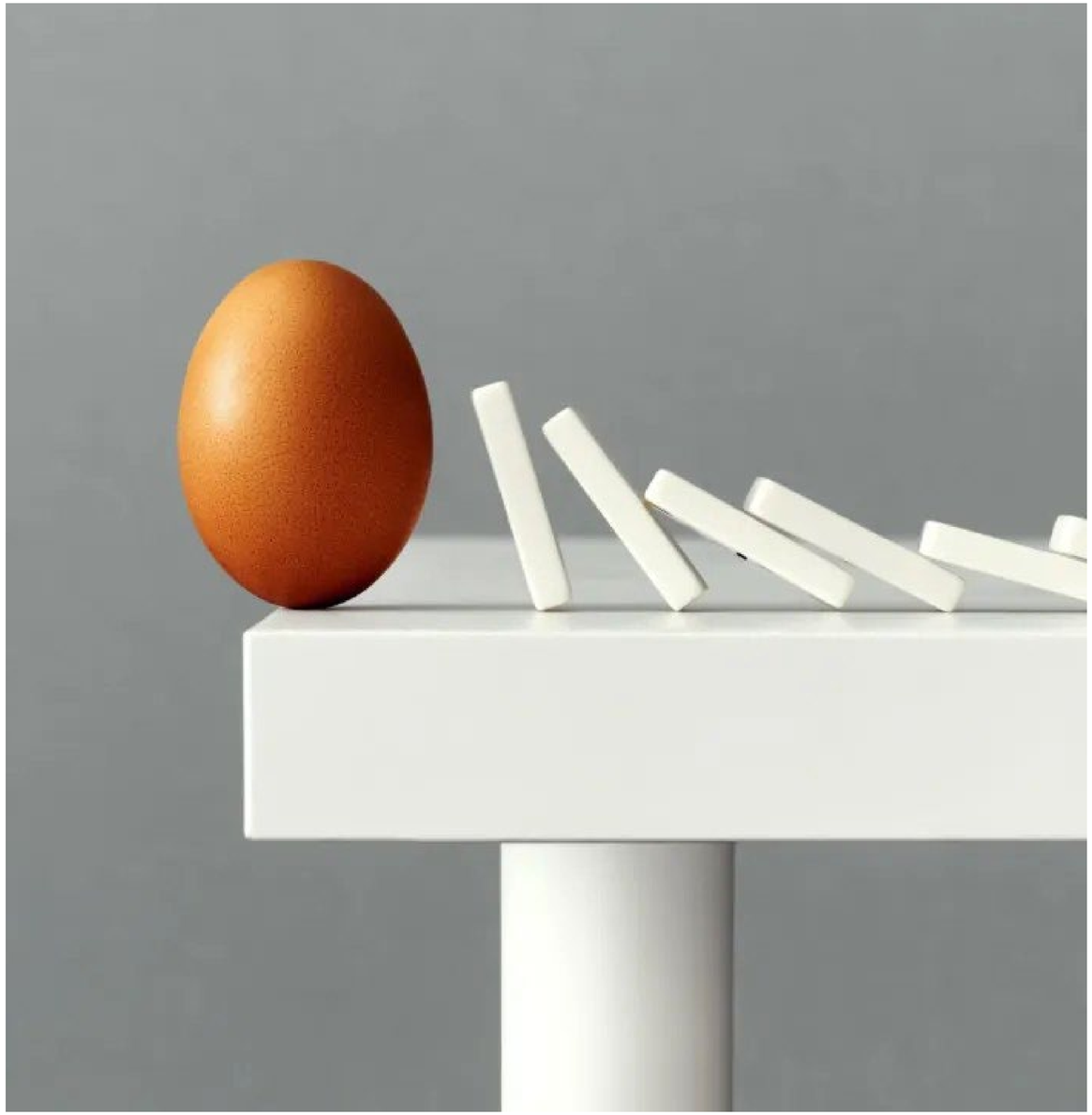
64% % of physicians who were independent in **2012**

47% % of physicians who were independent in **2016**



Where does this end?

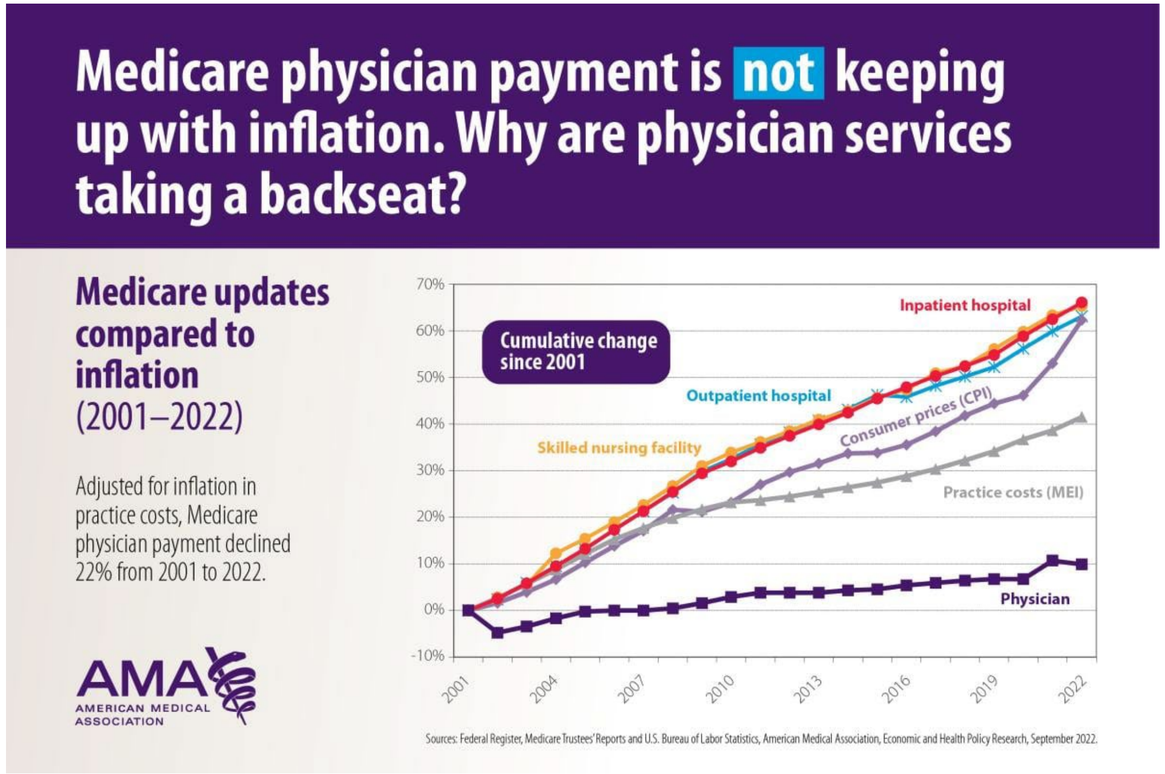
- Government breaks up the monopolies and limits insurance company influence leading to private practice increases?
- Consolidation begets consolidation until we bankrupt the system and end up in a single payer model?



Solutions and Predictions

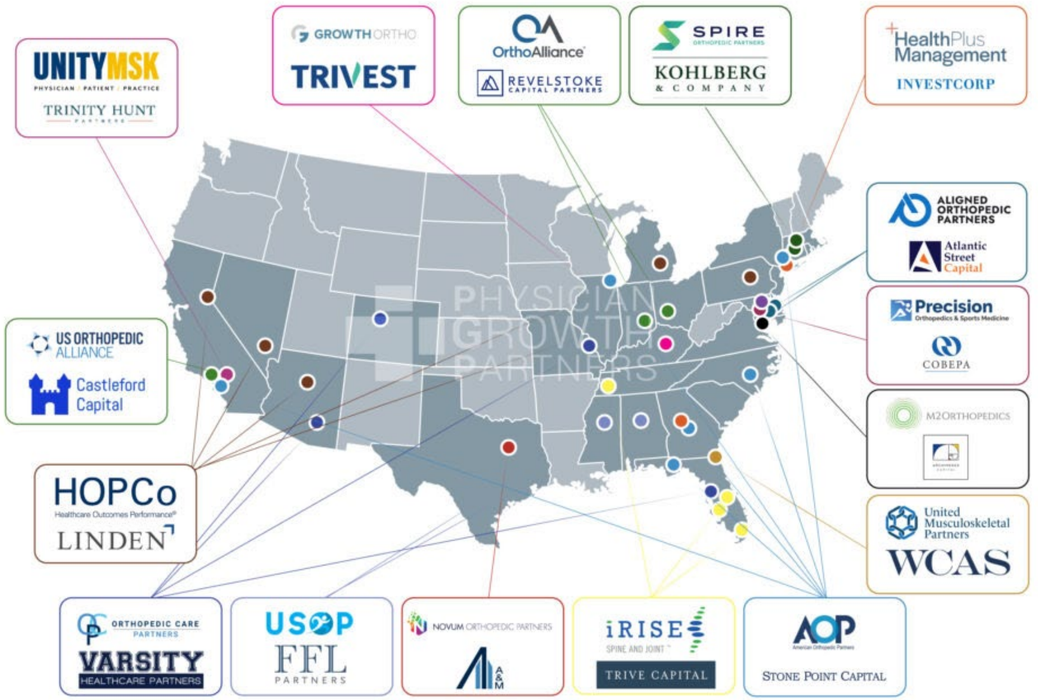
Medicare Reform

- Unsustainable process
- Physician pay increasingly coming from ancillaries
- Long term reform to MEI:
  - Limited support currently
  - Conversation needs to start somewhere
  - Cost in excess of $100B
  - Does consolidation and PE ultimately turn the tide towards true reform?

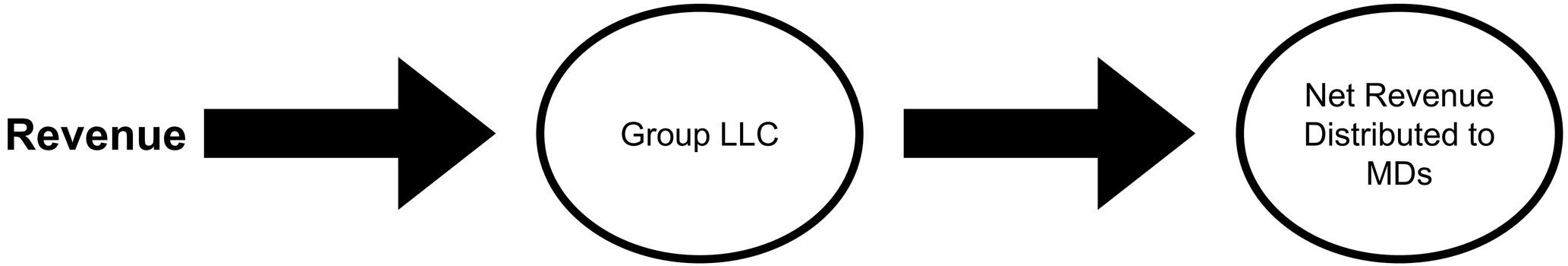


Private Equity

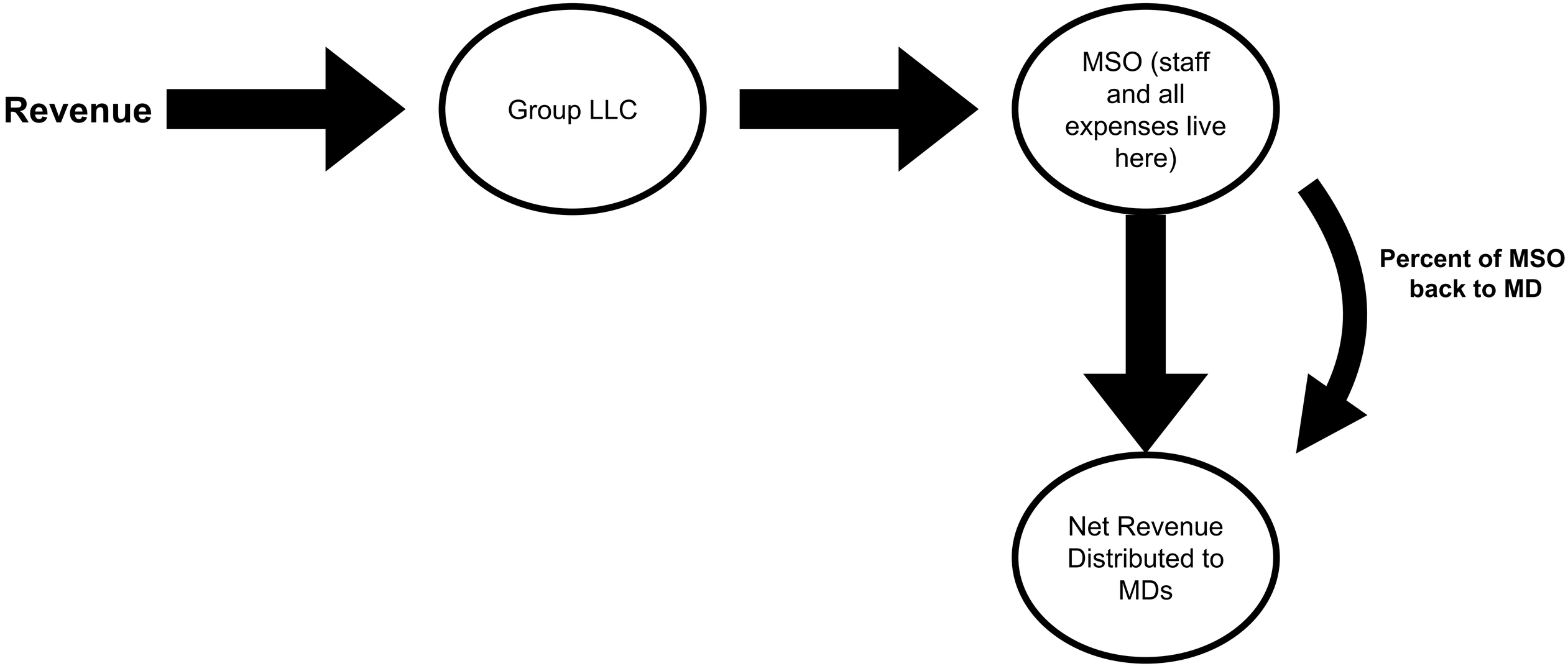
- Significant headwinds currently with interest rates
- Many, if not most, are set up to fail
- There may be a handful of models that lead to good short term results
    - But what do long term results look like?



Quick look at how it works



In a PE model, it looks like this:



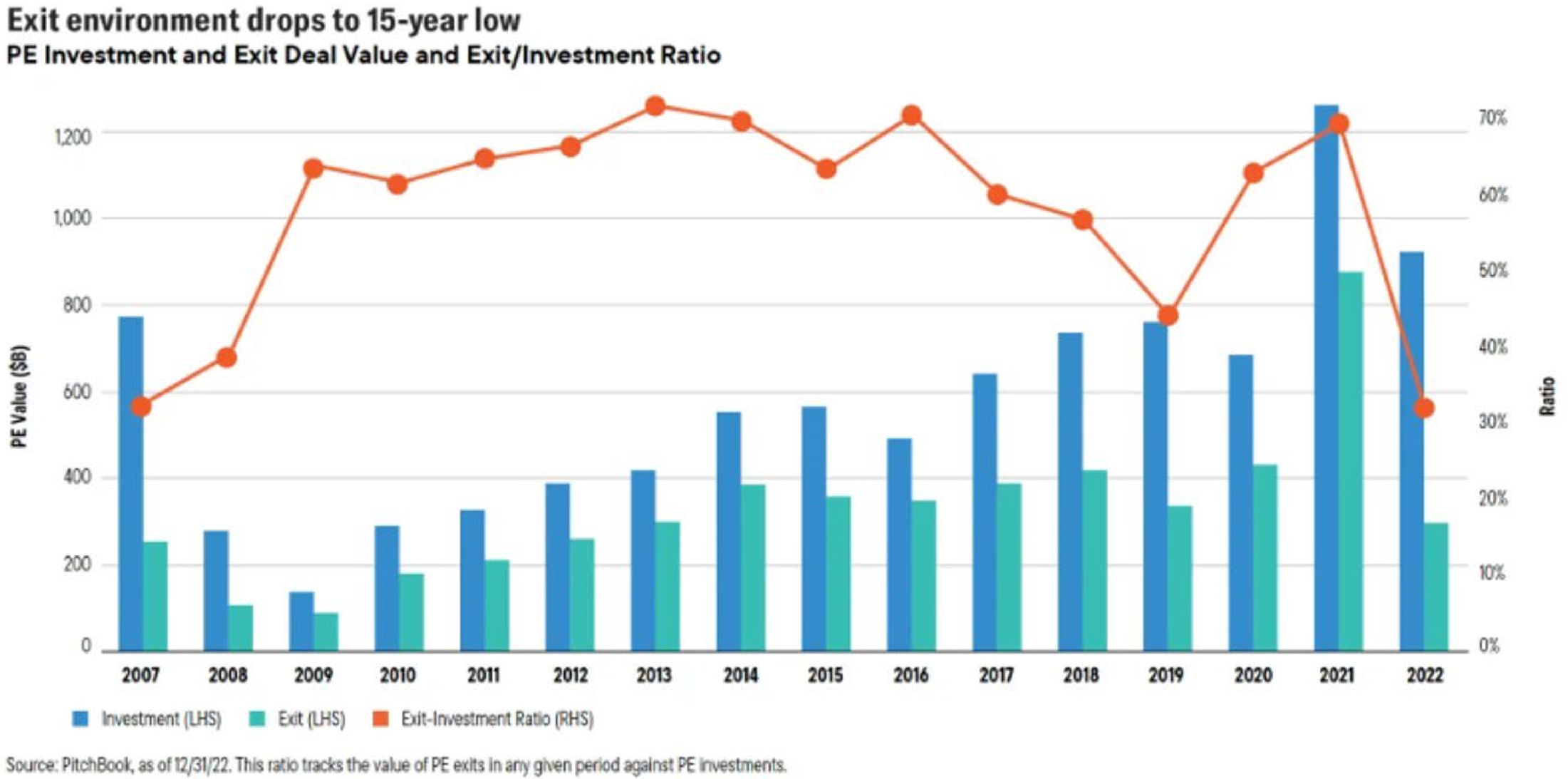
PE - Putting Numbers to it

- Pre-Acquisition
  - Gross Revenue of Group - $20M
  - Net Revenue of Group - $10M
  - Distributions/W2 to MDs - $10M
- Post-Acquisition
  - Gross Revenue of Group - $20M
  - Net Revenue of Group - $10M
  - Management Fee for MSO - $3.33M
  - W2 to MDs - $6.67M
  - Management Fee revenue to MDs - $1.67M (assuming they own 50%)
  - Net to MDs - $8.33M

The “second bite”

- The entire goal of this arrangement for physicians is to ultimately get to a “second bite”
- This is when another Private Equity company comes in and buys out the first one at a multiple of the first purchase
- Theoretically the physicians either sell all or a portion of their ownership in the MSO to capitalize

Is it even coming?



Source: PitchBook, as of 12/31/22. This ratio tracks the value of PE exits in any given period against PE investments.

PE - Putting Numbers to the Second Bite

- Pre-Acquisition
  - Gross Revenue of Group - $20M
  - Net Revenue of Group - $10M
  - Distributions/W2 to MDs - $10M
- Post-Acquisition
  - Gross Revenue of Group - $20M
  - Net Revenue of Group - $10M
  - Management Fee for MSO - $3.33M
  - W2 to MDs - $6.67M
  - Management Fee revenue to MDs - $1.67M (assuming they own 50%)
  - Net to MDs - $8.33M
- Post Second Bite
  - Gross Revenue of Group - $20M
  - Net Revenue of Group - $10M
  - Management Fee for MSO - $3.33M
  - W2 to MDs - $6.67M
  - Management Fee revenue to MDs - $0
  - Net to MDs - $6.67M

What is the Value Add?

- Typically PE company provides no different capabilities than you start with
- Strategy is the same - cut costs, expand size, increase ancillaries
- Adding more doctors does or locations for the most part does not increase reimbursement…. So combining to improve contracting likely won't happen
- It is quite challenging, particularly for larger groups, to make up the difference in income lost
- Few PE firms are truly leading through MD management - they are leading through business persons who have limited experience in orthopedics

What is the PE goal?

- Simply put…. Their goals are to focus on
  - short term revenue generation
  - consolidation of assets
  - Limited concerns for long term patient quality or financial stability
- How do they do it?
  - Prioritize revenue over quality
  - Increase debt vehicles (in many cases overburdening the organization)
  - Strip assets
- What is the result?
  - Long-term failures
  - Worse health outcomes
  - Higher Prices

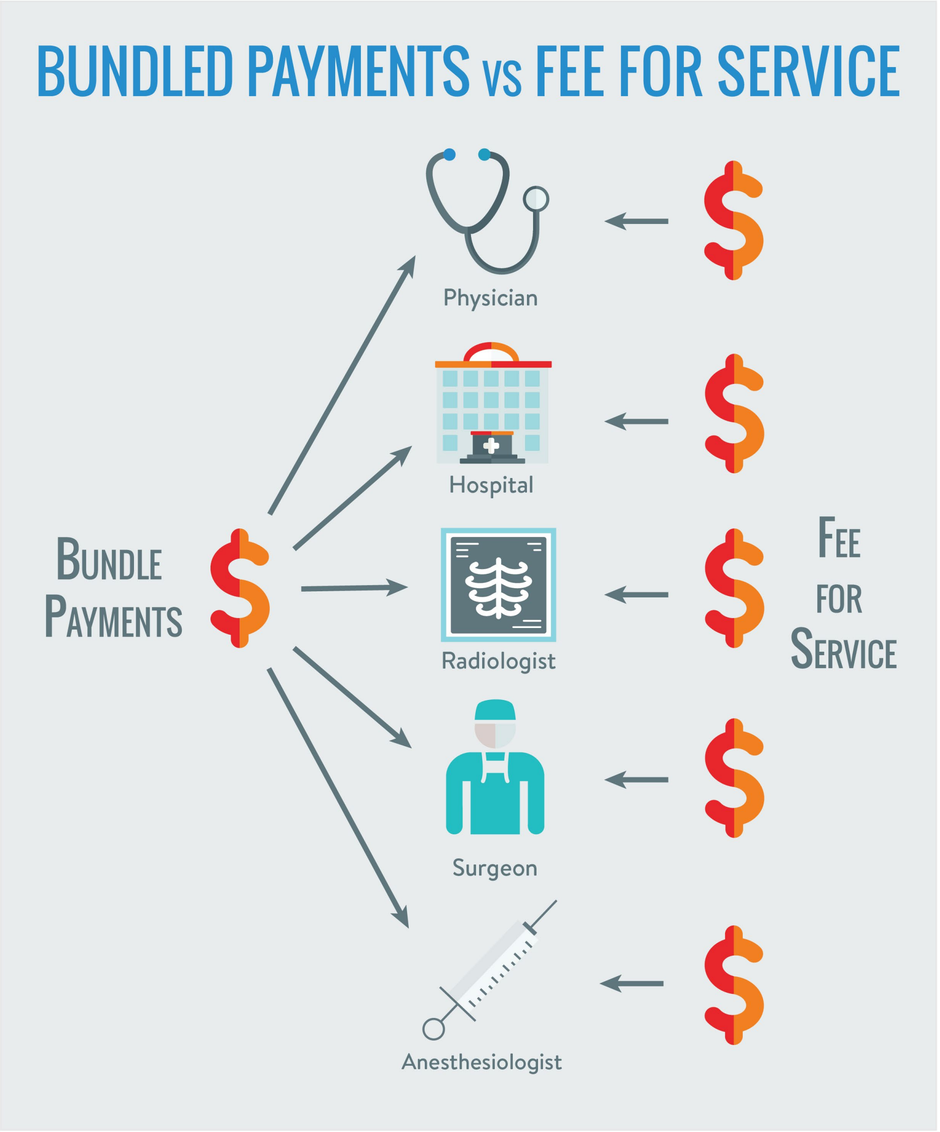
Be Very Careful

- Private equity can:
  - Be a funding source if you cannot obtain the funding from a bank or other source
  - Create collaboration for future partnerships
- Private Equity likely cannot:
  - Transform your business
  - Transition you to value based care
  - Rapidly improve operations or bottom line
  - Ultimately drive more income into the practice

VBC, CJR, BPCI

Scary acronyms or the future?

- Brief History:
  - Started out strong…. Several groups did well
  - Ended up rough…. Several groups pulled out
- So where are we going?

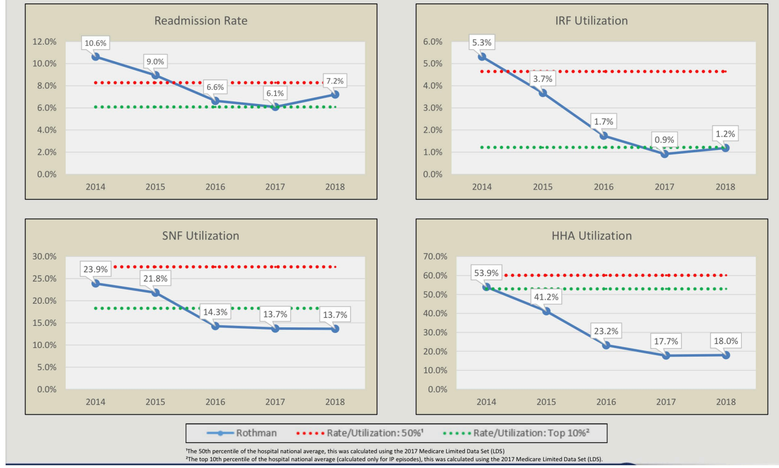


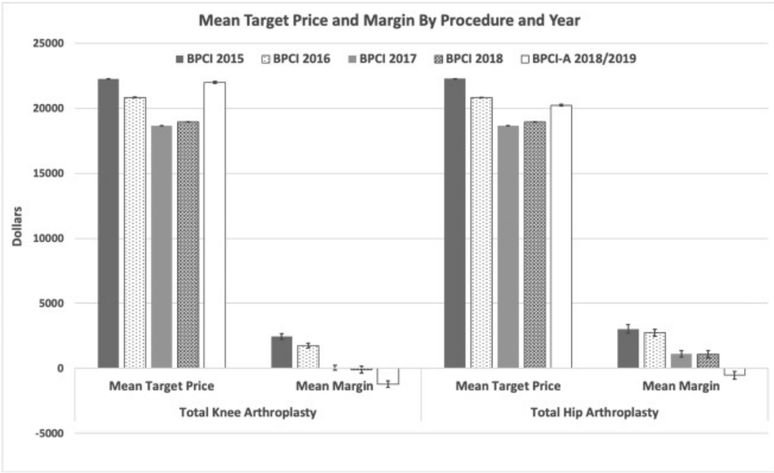
EOC SHARED SAVINGS

By Payer & Episode (2015-2019)

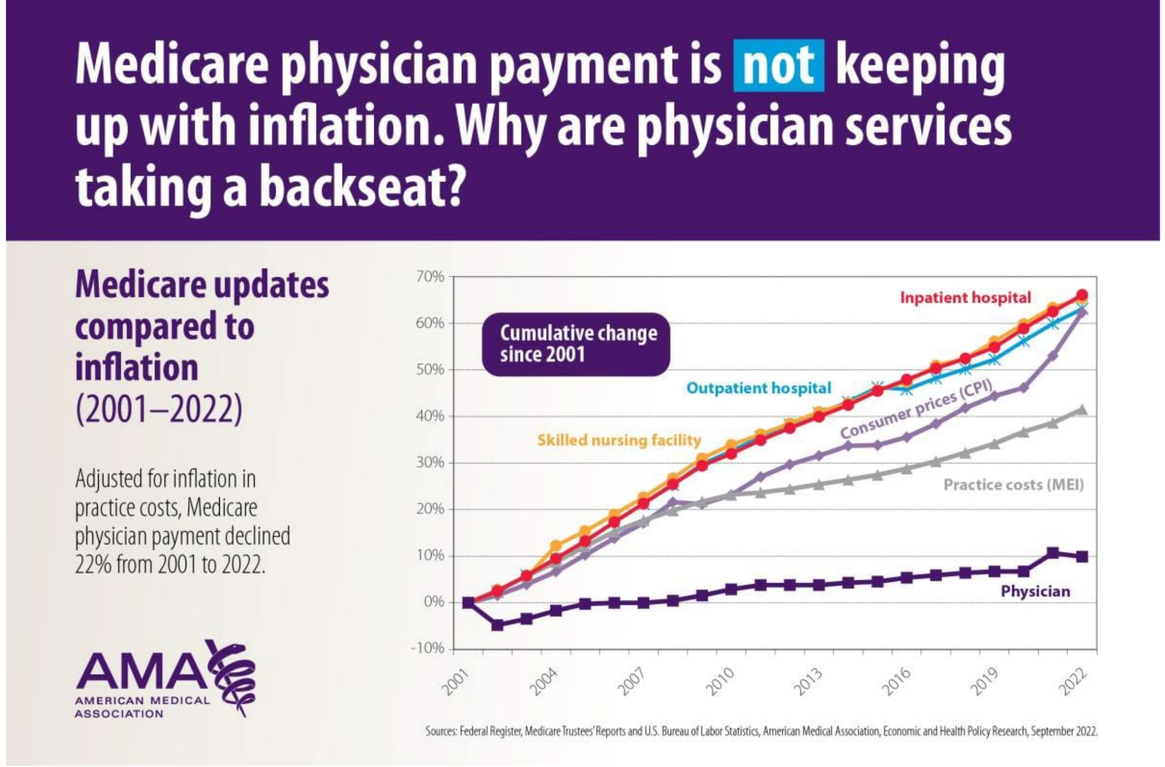
Payer	Program	2015	2016	2017	2018	2019	5-Yr Total
Aetna	TJA @ SH			$157,143	$942,857	$1,268,348	$2,368,348
Cigna	THA						-
	TKA				$24,922	$21,184	$46,106
	Knee Arthrosc				$14,338	$12,187	$26,525
	L/S Lami				$82,296	$69,952	$152,248
CMS BPCI	C/S Fusion	$34,033					$34,033
	TJA	$2,069,981	$2,874,321	$3,082,737	$1,664,276	-	$9,691,315
CMS BPCI-A					($1,459,262)	($6,930,938)	**($8,390,200)**
CMS BPCI Gainshare	TJA		$385,315	$1,410,569	$909,073	-	$2,704,957
Horizon BCBS NJ	Knee Arthrosc - NJ		$113,187	$326,536	($95,280)	$165,690	$510,133
	Knee Arthrosc - PA		$275,889	$254,115	$68,694	$86,503	$685,201
	THA w/AtlantiCare	$1,687,366	$1,954,828	$2,603,517	$489,809	$497,745	$7,233,265
	TKA w/AtlantiCare	$2,841,620	$3,087,502	$4,557,326	$409,208	$417,392	$11,313,048
	THA - NJ		$239,680	$355,460	$77,432	$52,343	$724,915
	TKA - NJ		$288,212	$685,290	$226,311	$163,348	$1,363,161
	THA - PA		$864,234	$810,538	$232,814	$311,690	$2,219,276
	TKA - PA		$532,496	$943,444	$657,830	$534,844	$2,668,614
	LBP - NJ		$468,213	$421,392	$422,562	$431,013	$1,743,180
	LBP - PA		$19,231	$17,308	$17,356	$17,703	$71,598
	TSA - NJ			$325,058	$418,041	$725,171	$1,468,270
	TSA - PA			$325,058	$177,163	$725,171	$1,227,392
IBC	TJA	$2,616,613	$5,700,569	$7,770,050	-	-	$16,087,232
	THA				$748,652	$785,179	$1,533,831
	TKA				$968,016	$858,737	$1,826,753
	Knee Arthroscopy				$492,800	$446,419	$939,219
	TSA				$56,000	$43,556	$99,556
	L/S Lami			$50,546	$245,600	$201,222	$497,368
	L/S Fusion				$137,600	$115,616	$253,216
Gross Savings		$9,249,613	$16,803,677	$24,096,087	$7,929,108	$1,020,075	$59,098,560
Net Savings Paid		$3,240,202	$6,829,577	$9,877,684	$2,620,168	-$2,889,889	**$19,677,742**
Share of Gross Savings		35%	41%	41%	33%	-283%	33%

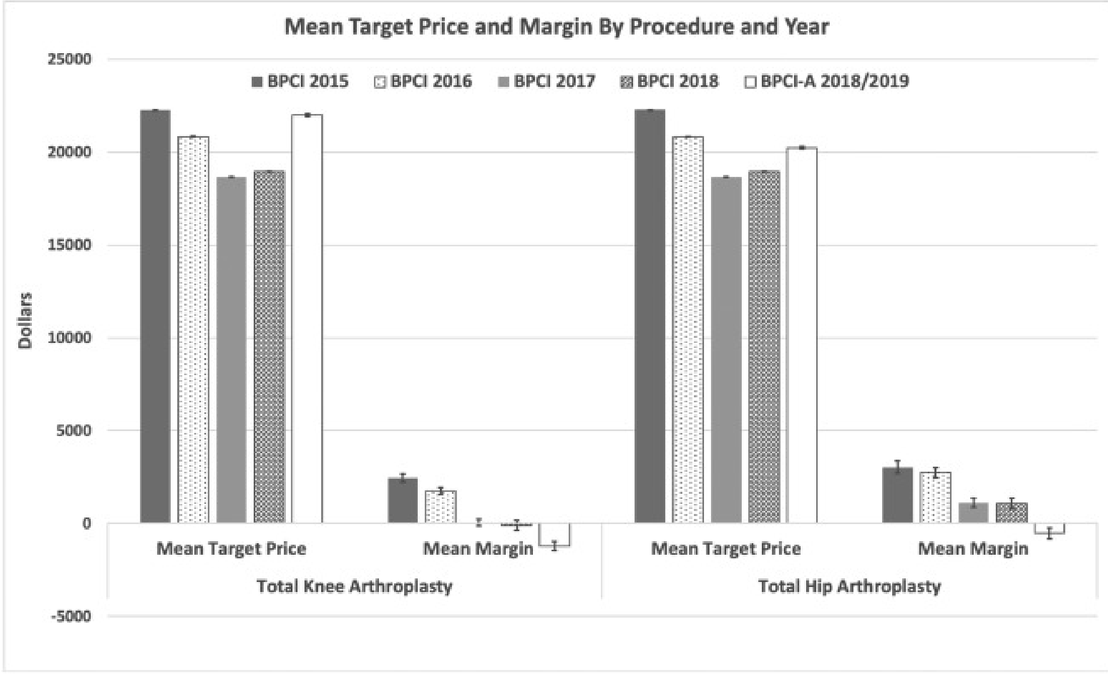
Historical Quality in BPCI





The race to the bottom?





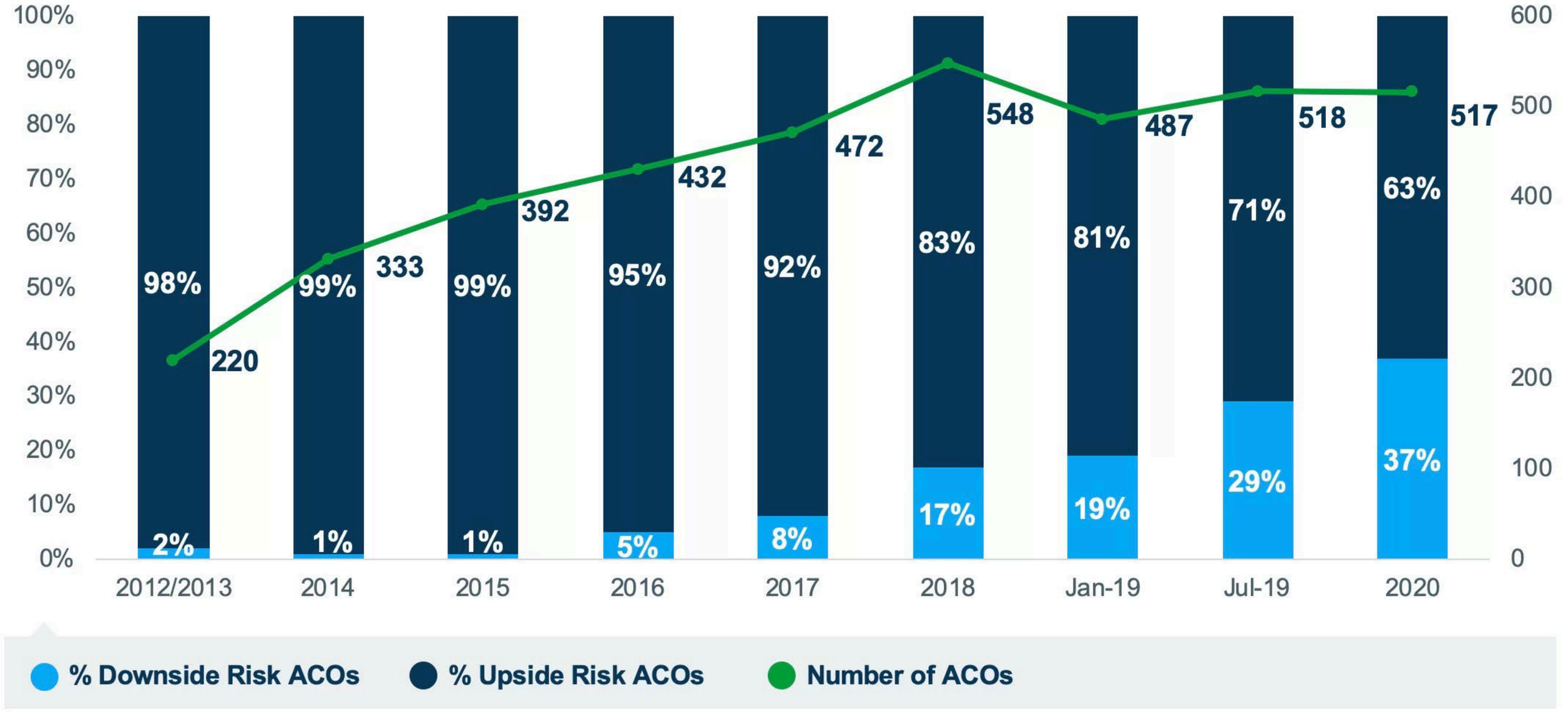
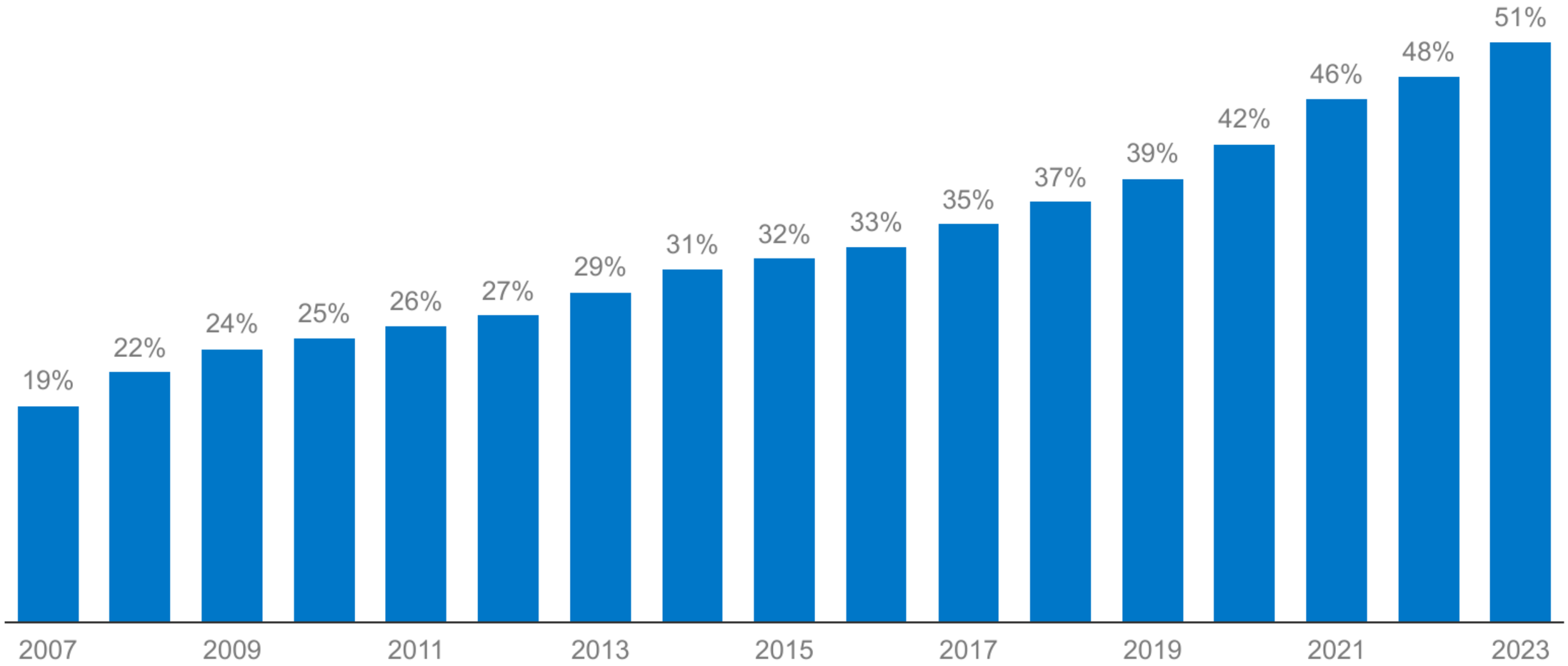


Figure 1

Total Medicare Advantage Enrollment, 2007-2023



NOTE: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 60.0 million people are enrolled in Medicare Parts A and B in 2023.

SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2023; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; and Medicare Enrollment Dashboard 2021-2023.

KFF

AAOS Recommendations: A Specialty Care Reimbursement Model to Operationalize Value-based Care for Musculoskeletal Conditions

Prepared and Reviewed by AAOS Healthcare Systems Committee
Karl M. Koenig, Chair

Acknowledgement and Additional Author credits:
"Developing High Value Condition Based Bundled Episode Payment and Practice Models for Musculoskeletal Care: A Playbook"

Developed by:

The Consortium for the Next Generation Alternative Payment Models **
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Jonathan O'Donnell

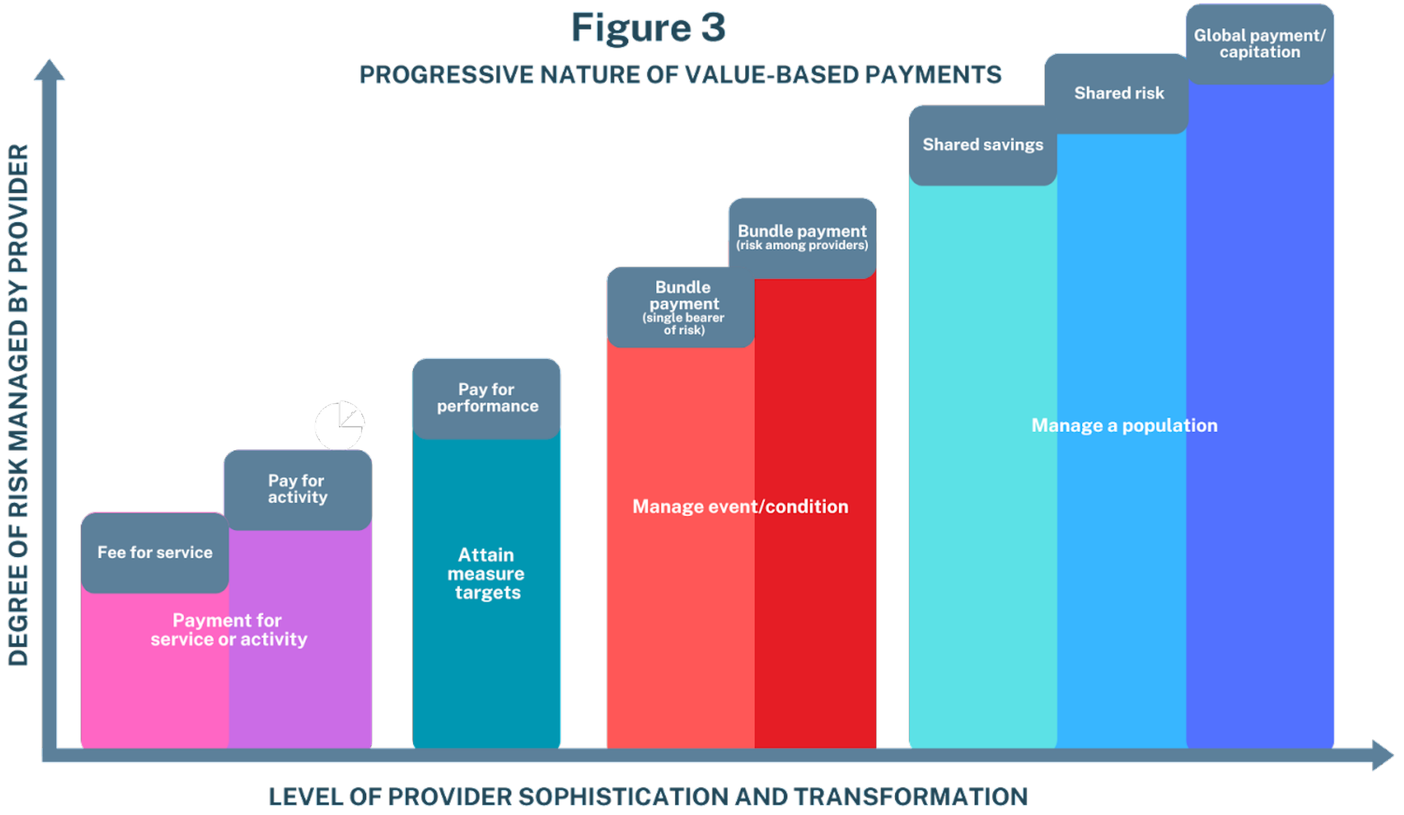
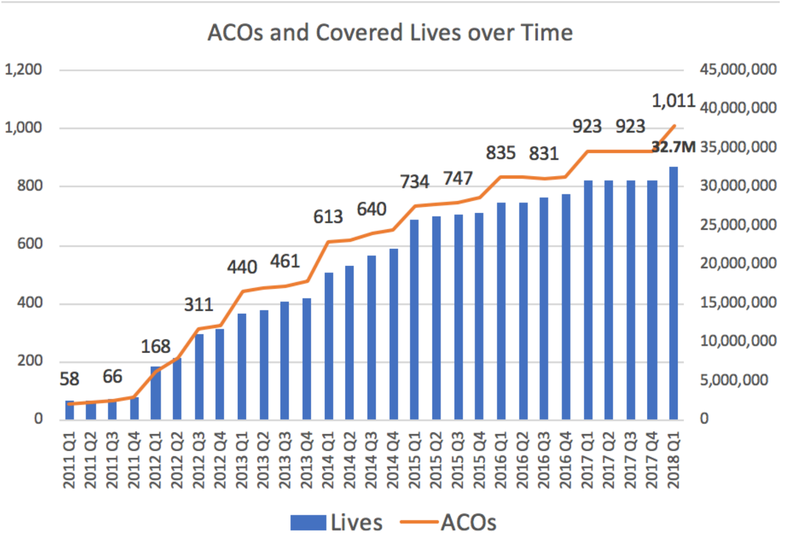


Figure 3
PROGRESSIVE NATURE OF VALUE-BASED PAYMENTS
DEGREE OF RISK MANAGED BY PROVIDER
LEVEL OF PROVIDER SOPHISTICATION AND TRANSFORMATION
Fee for service
Pay for activity
Payment for service or activity
Pay for performance
Attain measure targets
Bundle payment (single bearer of risk)
Bundle payment (risk among providers)
Manage event/condition
Shared savings
Shared risk
Global payment/ capitation
Manage a population


ACOs and Covered Lives over Time
1,200
1,000
800
600
400
200
0
45,000,000
40,000,000
35,000,000
30,000,000
25,000,000
20,000,000
15,000,000
10,000,000
5,000,000
0
58
66
168
311
440
461
613
640
734
747
835
831
923
923
1,011
32.7M
2011 Q1
2011 Q2
2011 Q3
2011 Q4
2012 Q1
2012 Q2
2012 Q3
2012 Q4
2013 Q1
2013 Q2
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2013 Q4
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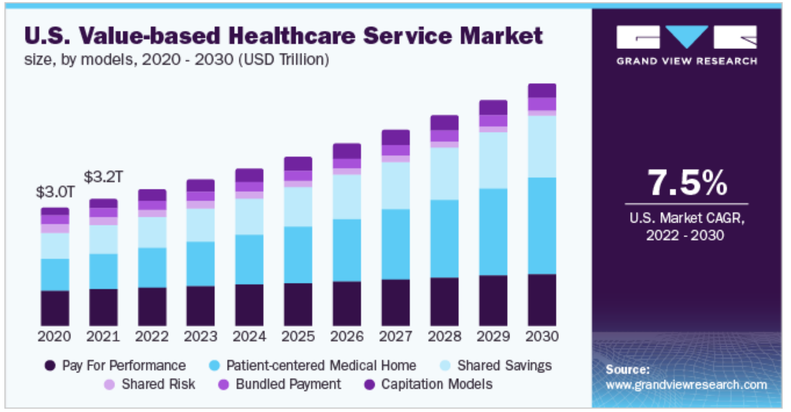
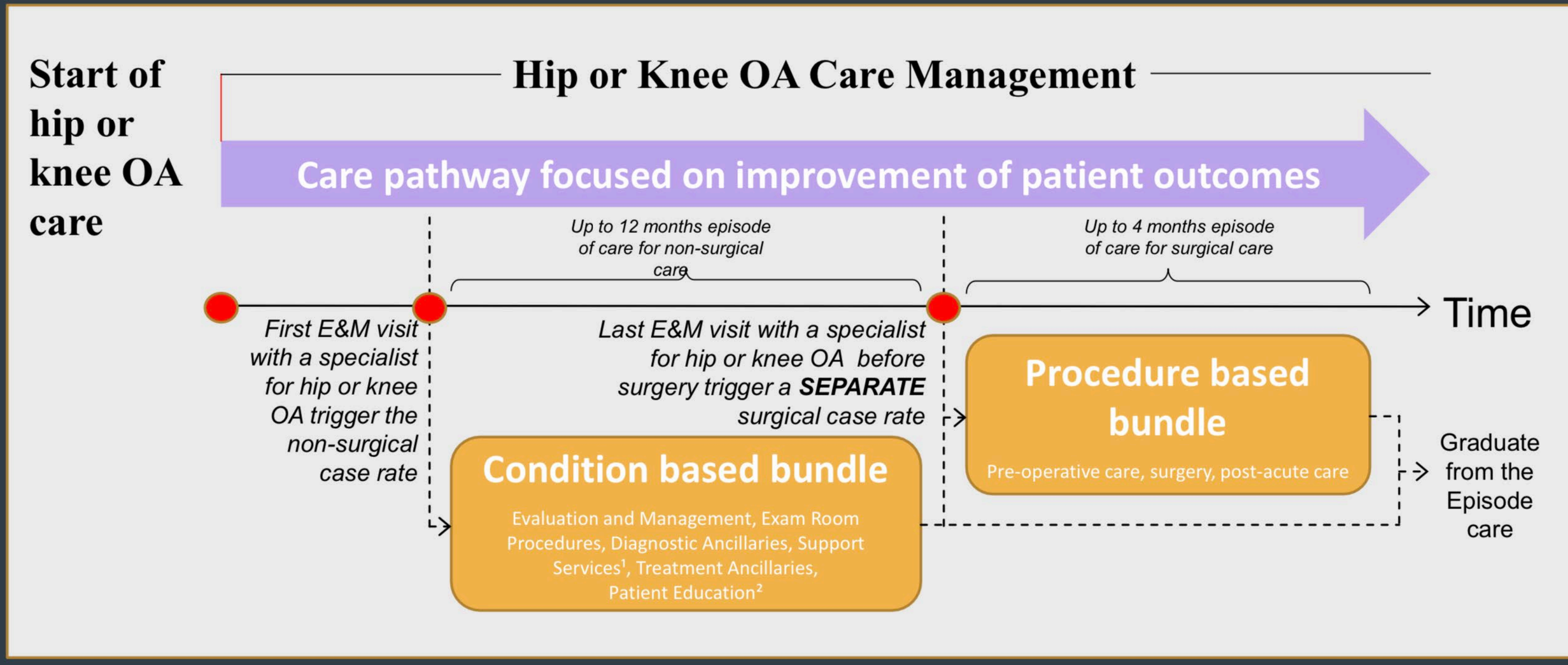
2018 Q1
Lives
ACOs


U.S. Value-based Healthcare Service Market
size, by models, 2020 - 2030 (USD Trillion)
$3.0T
$3.2T
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
Pay For Performance
Patient-centered Medical Home
Shared Savings
Shared Risk
Bundled Payment
Capitation Models
GRAND VIEW RESEARCH
7.5%
U.S. Market CAGR, 2022 - 2030
Source: www.grandviewresearch.com

Alternative Payment Models for Hip and Knee OA



1. Support Services include DME, immunization/vaccine, etc. (only will be given if it is necessary);
2. Patient education includes service & materials fees, patient's history, registration, education, etc.